New Hampshire Veterans Home

139 Winter Street
Tilton, NH 03276

Barry E. Conway
Commandant

Telephone: (603) 527-4400
Fax : (603) 527-4850

Dear Applicant:

Thank you for your interest in the New Hampshire Veterans Home.

For more than a century, the Veterans Home has been a home and health resource for Granite State armed forces veterans. Established initially in 1890 as the Soldier's Home for Civil War Veterans, it has provided care and comfort for thousands who have served their country and fellow-citizens.

Located in the foothills of the magnificent White Mountains, the scenic beauty, along with the warm fellowship shared by residents, staff and volunteers make for a most appropriate environment for those who have made personal sacrifices in the military and are now unable to care for themselves.

You will find the eligibility requirements within the Application packet for admission to the Home. Our own requirements, along with Federal and State regulations, necessitate that all applicants for admission provide full and complete information on the forms provided in this packet. Please note any incomplete forms and/or information will result in a delay of the application process.

The Admissions Coordinators at 527-4846 or 527-4843 are available for questions regarding the application process and for scheduling a tour.

We look forward to hearing from you.

Sincerely,

Barry E. Conway
Commandant

BEC:amb

Enclosures

NH VETERANS HOME
APPLICATION INSTRUCTIONS

If you meet the following Admissions Criteria, you are eligible for consideration for admission to the NH Veterans Home:

* Ninety days of service during time of war (as defined by Title 38 US Code Section 101) and honorably discharged.
* The applicant has been a resident of the State of New Hampshire for one (1) year preceding his or her application.
* The applicant's condition(s) are within the Home's resources and ability to treat, and that the applicant does not present potential harm to self or other Residents.
* Financial Certification (see page 3)

Applicant Completes the Following:

(If a Physician has certified the Veteran lacks the capacity to understand his/her medical needs and has activated his Durable Power-of-Attorney for Health Care or there is a Guardian of the Person in place; then that designated person can complete the required paperwork).

* Application Sheets (pages 1 and 1A)
* Final Requests Form (page 2)
* Financial Affidavit (page 3A)
* Applicant Agreement Form (page 4)
* (3) Medical Release Forms (page 6)
* Review and keep Notice of Privacy Practices (page 7)
* Consent for Care & Treatment/Use of Health Care Information/Acknowledgement of Privacy Notice page 8
* Security Form (Page 9)
* Criminal Record Release Authorization Form (last page) - your signature in both places must be witnessed by a notary to be valid, per the state law. There is no fee.

Your Doctor Completes:

1. Medical Information, pages 5, 5A, 5B
   (This includes a TB (mantoux) test, urinalysis, complete blood count, and chest X-ray required within three months of the application date)

Documentation to be included:

1. **Original** DD-214 or other military papers showing entry and discharge dates with type of discharge. The original will be returned to you after VA verification.
2. Copies of any Health Insurance Cards, including Medicare.
3. Copies of Advanced Directives (Living Will, Power of Attorneys for Healthcare/ Finances) or Guardianship papers
4. Certified Marriage Certificate or Divorce Decree.
5. Copy of proof of financial assets and monthly income **for one year** include any Trust, Long Term Care Insurance Policies and the Deed to the house if applicable.

NH VETERANS HOME ADMISSION APPLICATION\

Full Name: _____ SS #: _____

Address:_____ Phone #: _____
_____

Where have you lived in the past two years?_____

DOB: _____Place of Birth:_____ Male:_____ Female:_____
Religion:_____ Education Level: _____
Previous Occupations: _____
Married: _____ Divorced:_____ Widowed: _____ Single:_____ Separated:_____

MILITARY INFORMATION:

Branch of Service: _____
Service Period: _____
Service Connected Disability? ___No ___ Yes, What %_____
Type of Service Disability: _____
VA Claim Number:_____
Date of Enlistment: _____Place of Enlistment:_____
Date of Discharge:_____ Place of Discharge:_____
Grade and Organization:_____Type of Discharge: _____
Veterans Service Groups:_____ Post#:_____
_____ Post#:_____

MEDICAL INSURANCE INFORMATION: (please provide copies)

Medicare: Part A ____ Part B ____Number:_____
Other Insurances:_____Policy #:_____

MEDICAL INFORMATION:

Who is your Primary Care Physician?_____Tel #:_____
Address: _____
_____

What hospitals have you been in during the last two years?_____
_____
VA Hospitals? yes_____no_____ where?_____
_____

LEGAL/CONTACT INFORMATION

LEGAL INFORMATION: Do you have any of the following? If so, please include copies.

	Yes	No	Name
Power of Attorney for Healthcare	___	___	_____
Power of Attorney for Finances	___	___	_____
Living Will	___	___	_____
Court appointed Guardian	___	___	_____
Conservator	___	___	_____

SPOUSE:

Name _____ Phone Numbers: Home _____
Address _____ Work _____
_____ Other _____

Date of Birth: _____
Social Security #: _____
Date of Marriage: _____
Date of Death (if applicable)_____

1ST CONTACT PERSON:

Name _____ Phone Numbers: Home _____
Address _____ Work _____
_____ Other _____
Relationship: _____

2ND CONTACT PERSON:

Name _____ Phone Numbers: Home _____
Address _____ Work _____
_____ Other _____
Relationship: _____

_____ _____
Witness Signature (Required) Veteran's Signature or
Legally Authorized Person
(DPOAHC, Guardian)

_____
Date

Name:_____ SS #: _____

FINAL REQUESTS

The following instructions direct the New Hampshire Veterans Home of my wishes in regards to final services in the event of my demise while a resident of the home.

Name and address of Funeral Home: _____

_____

_____

Phone Number: _____

Location of cemetery plot: _____
Purchaser's name of plot: _____
Have these arrangements been prepaid? _____ Yes _____ No

Special instructions, i.e.: military funeral, private services, cremation, etc.:
_____
_____

Do you still have your Soldier's Life Insurance? _____ Yes _____ No

Do you have a will? _____ Yes _____ No If yes, where is it located?
_____

If funeral arrangements have not been made, the applicant understands that they must be completed within 60 (sixty) days of admission to the Veterans Home.

I understand that all personal property left at the Home 30 (thirty) days, after my departure, shall become property of the Home.

_____
Applicant's Initials

_____
Date

FINANCIAL COST INFORMATION

The financial cost to the veteran for residing at the Veterans Home is dependent on the veteran's total assets. See below:

- **ASSETS less than $30,000** -

The veteran's monthly liability to the home is based on the following formula:

Veteran's total monthly income	=	$
Deduct $l00.00 (for the veteran)		- l00.00
New total of monthly income:	=	
Multiply by		X .90
This is the monthly cost to the veteran	=	$

The l0% difference is for personal needs, and items not covered.

- **ASSETS BETWEEN $30,000 – $ 275,000;**

The veteran will be a self-pay resident at a daily rate of $ 125.00*****

***subject to yearly rate increase**

ROOM AND BOARD CHARGES include: all prescription medications, 24 hour nursing care, Physical Therapy for maintenance/restorative care only, recreational activities, transportation to and from medical appointments ordered by the NHVH MD, all dietary services (three meals and snacks), daily housekeeping services, laundry services**,** incontinency products, basic cable TV, routine dental care, management of Resident Account, co-ordination of VA/Pension benefits, Social Services, Library services.

EXPENSES NOT COVERED: Additional medical services may be required that are not covered by the room and board rate and of which may or may not be covered by the VA , Medicare, or other health care insurances you may have. Other items not covered are: 20 % Medicare co-pay, supplemental health care insurance premiums cost, hair cuts, personal clothing, personal toiletries, eyeglass prescriptions, dentures/partial plates (new or repaired), hearing aides (new or repaired**),** personal cell phones, personal computers, private travel to local banks, fees for legal documents, legal services, personal snacks, out of house meals, entertainment equipment as TV's, DVD's, CD's, Radios, etc and some durable medical equipment.

APPLICANT'S FINANCIAL AFFIDAVIT FOR NHVH

Name:_____ SS #:_____

ASSETS:	**VETERAN:**	**SPOUSE:**	**JOINT:**	**Liabilities:**
Checking Accounts	$_____	$_____	$_____	
Saving Accounts	$_____	$_____	$_____	
Certificates of Deposit	$_____	$_____	$_____	
Investments:				
Annuities	$_____	$_____	$_____	
Mutual Funds	$_____	$_____	$_____	
Bonds	$_____	$_____	$_____	
IRA's	$_____	$_____	$_____	
401 K's	$_____	$_____	$_____	
Stocks	$_____	$_____	$_____	
Other Ret. Benefits	$_____	$_____	$_____	
Property:				
Residence (value)	$_____	$_____	$_____	$_____ (mortgage)
Other real estate	$_____	$_____	$_____	$_____ (mortgage)
Rental income	$_____	$_____	$_____	$_____
Time share	$_____	$_____	$_____	$_____
Business ownership	$_____	$_____	$_____	$_____
Loans due you	$_____	$_____	$_____	

Alimony/Child Support Yes_____ No_____ How much per month_____

Long Term Care Insurance: Yes_____No_____ Rate per day:_____

Length of coverage_____

TRUSTS: Yes _____ No _____ Revocable_____Irrevocable_____

MONTHLY INCOMES:	**VETERAN**	**SPOUSE**
Social Security	$_____	$ _____
Military Retirement	$_____	$_____
Federal, State or City Retirement	$_____	$_____
Railroad Retirement	$_____	$_____
Other Retirement	$_____	$_____
Non-Service Connected Compensation	$_____	$_____
Service Connected Compensation	$_____	$_____
Interest on Investments:	$_____	$_____
Income from other sources as rental, loans due you, etc	$_____	$_____
Total monthly income:	$_____	$_____

NEW HAMPSHIRE VETERANS HOME
AGREEMENT FORM

I understand the NH Veteran's Home is owned and operated by the State of New Hampshire and therefore, subject to the rules of the State.

I give permission to the NH Veterans Home to provide requested information as needed to the Department of Veterans Affairs. This includes spouse's income and social Security number, which is required to determine VA benefits.

I agree to abide by the NH Veterans Home rules and regulations established by the Commandant, the Board of Managers and the State of New Hampshire.

I verify that the assets listed in this application are accurately stated. I verify that I have not transferred any assets in the twelve-month period prior to applying to the New Hampshire Veterans Home, for the sole purpose of complying with the eligibility requirements.

I will provide proof of financial assets and monthly income during the admission process and anytime thereafter, upon request by the Business Office, in determining my monthly cost of care.

I agree to accept transfer/discharge to another facility capable of providing for my needs if the NHVH does not have the resources and is advised by the Medical Director.

I have read, or had read to me and understand the information provided in this application.

The information given in this admission application is true and correct to the best of my knowledge and belief. The New Hampshire Veterans Home reserves the right to request updated information regarding this application.

I certify there are no willful misrepresentations or answers to questions. If an investigation discloses such misrepresentations, my admission to the Home maybe denied. If I should already be a Resident, I may be discharged from the Home.

_____ _____

Witness Signature (required) Veteran's Signature or legally authorized Person (DPOAHC/Guardian)

_____

Date

INSTRUCTIONS TO PHYSICIAN

1. **Please complete Pages 5A & 5B.**

2. **Results of current (within last 3 months) Chest X-Ray, TB Test, Urinalysis, and CBC are required.**

   Note: If PPD is positive and the patient has not been treated, the NHVH will require negative sputum testing. (Three samples of sputum at least 24 hours apart)

3. **Physician's Signature is required at the bottom of Page 5A and where indicated on 5B.**

4. **Please call the Admissions Department at 527-4846 or 527-4843 if we can be of any assistance. Thank you.**

OMB Approval No. 2900-0160
Estimated Burden: Avg. 30 min.

Department of Veterans Affairs

STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

PART I - ADMINISTRATIVE

STATE HOME FACILITY	DATE ADMITTED	GENDER
New Hampshire Veterans Home		M F
RESIDENT'S NAME (*Last, First, Middle)*	SOCIAL SECURITY NUMBER	
RESIDENT'S STREET ADDRESS	AGE	DATE OF BIRTH
CITY, STATE AND ZIP CODE	ADVANCED MEDICAL DIRECTIVE	NO YES

PART II - HISTORY AND PHYSICAL *(Use separate sheet if necessary)*

HISTORY

HEIGHT	WEIGHT	TEMP	PULSE	BP	HEAD/EYES/EAR/NOSE AND THROAT

NECK	**CARDIOPULMONARY**
ABDOMEN	**GENITOURINARY**
RECTAL	**EXTREMITIES**
NEUROLOGICAL	**ALLERGY/DRUG SENSITIVITY**

X-RAY/ LAB	**CHEST X-RAY**	DATE:	RESULTS	**CBC**	DATE:	RESULTS
	SEROLOGY					
	URINALYSIS	**DATE**	ALBUMEN	SUGAR		ACETONE

CHECK ALL BOXES THAT APPLY OR CIRCLE NA

IS DEMENTIA THE PRIMARY DIAGNOSIS	IS THERE A DIAGNOSIS OF MENTAL ILLNESS	HAS RESIDENT RECEIVED MENTAL SERVICES WITHIN THE PAST 2 YEARS	IS CLIENT A DANGER TO SELF OR OTHERS
YES NO	**YES NO**	**YES NO**	**YES NO**

IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS:

SCHIZOPHRENIA PARANOIA OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY

MOOD SWINGS SOMATOFORM DISORDER PANIC OR SEVERE ANXIETY DISORDER PERSONALITY DISORDER

OXYGEN		TUBE FEEDING	DECUBITUS ULCERS	**FOLEY CATHETER**
MASK	PRN	OSTOMY	DRAINING WOUND	TEMPORARY
NASAL CANULAR	CONTINUOUS	TRACHOSTOMY	WOUND CULTURED	PERMANENT

REFERRING PHYSICIAN	PRIMARY DIAGNOSIS
SECONDARY DIAGNOSIS	TERTIARY DIAGNOSIS

TYPE OF CARE RECOMMENDED: SKILLED NURSING HOME CARE DOMICILIARY CARE ADULT DAY HEALTH CARE HOSPITAL

MEDICATION AND TREATMENT ORDERS ON ADMISSION, CONTINUE ON SEPARATE SHEET IF NECESSARY

PRINTED OR TYPED NAME OF PRIMARY PHYSICIAN ASSIGNED	SIGNATURE OF PRIMARY PHYSICIAN ASSIGNED

MEDICAL INFORMATION FOR NHVH ADMISSION APPLICATION

_____ _____ _____
Name DOB Social Security #

Immunizations:
Date of Last Tetanus Booster: _____ Has Applicant had Pneumovax? _____
Date of Last Flu Shot: _____
PPD (Required within 3 months of Application Date): Date _____ Results _____
Is Applicant free of communicable disease, including TB? _____ Yes _____ No
If no, explain: _____

Self Care Status:
Can applicant do the following:

	Yes	No
Dress self?	_____	_____
Feed self without assistance?	_____	_____
Use bathroom without assistance?	_____	_____
Incontinent? Bowel	_____	_____
Bladder	_____	_____
Does applicant exit seek?	_____	_____

Diet Order:
_____

Activity Order:
_____

Mobility Status:
Ambulatory ___ Cane ___
Wheelchair ___ Walker ___

Does the Applicant have the capacity to understand Health Care Issues?
Yes _____ No _____
Has the Durable POA for Health Care been activated? Yes___No _____Date_____

Past History:	Yes	No	Year	Where Treated?
TB				
Psychiatric Treatment *				
Alcohol Abuse				
Drug Abuse				

***Include Psych Consult, if applicable**

Physician Signature: _____, MD **Date of Exam: _____**
Physician's Name & Address (Print) _____
_____ Phone:
_____ _____

FOR NH VETERANS HOME PHYSICIAN ONLY
_____ Recommend for Admission COMMENTS: _____
_____
_____ Not Recommended for Admission _____

Signature:_____ Date:_____

NEW HAMPSHIRE VETERANS HOME
139 WINTER STREET
TILTON, NH 03276

RELEASE OF INFORMATION

TO_____(Name of medical provider, i.e. Hospital, Physician, Rehab Center, VA Hospital, Nursing Home, VNA)

I, the undersigned, hereby authorize you to furnish a copy (ies) or allow a review of the medical record of:

_____	_____	_____
Name of Patient	Date of Birth	SS #

_____

Street City State Zip Code

Information requested is for the specific purpose of consideration for admission and for continued care if approved for admission to the New Hampshire Veterans Home:

*Discharge summaries for the past two years.
*Medical and psychiatric consults (including Treatment of Alcoholism/Drug Abuse) for the past two years.
*Chest x-rays and any laboratory results within the past 3 months.
*Immunization record for the past two years.
*Primary Care Provider and Consultant office notes for the past two years.
*LTC Facility Medical chart records as MDS,Medication list, Rehab consults/summaries, medical/psychological consults, SW assessments, Diet, MD orders, nursing notes, labs results, X-rays, Immunizations.

Please mail to: Admissions Coordinator
New Hampshire Veterans Home
139 Winter Street
Tilton, N.H. 03276

The information obtained herein is confidential, must be used solely for the purpose as stated, and may not be re-released. I also request that my consent become invalid one year from the date of signature. This authorization is subject to revocation at any time, unless action on it has already begun in good faith.

Signature: _____ Date:_____

Witness' Signature:_____ Date:_____

NEW HAMPSHIRE VETERANS HOME
139 WINTER STREET
TILTON, NH 03276

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Signature: _____ Date:_____

Witness' Signature:_____ Date:_____

New Hampshire Veterans Home

Notice of Privacy Practices

Effective Date: 02/15/2005

This notice describes how your health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. Introduction. This Notice of Privacy Practices describes how New Hampshire Veterans Home may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services.

II. Your Health Information Rights. While the actual records that we maintain about you belong to us, the information contained in our records belongs to you. Under the federal Privacy Rules (45 CFR Part 160 and Part 164) you have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR Part 160.522. Please note, however, that we are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your health information, we will notify you that your request for restriction will not be honored. If we agree to the requested restriction, we may not use or disclose your health information in violation of that restriction unless it is needed to provided emergency treatment.
- Obtain a paper copy of this Notice of Privacy Practices upon request
- Inspect and obtain a copy of your health record
- Amend your health record
- Obtain an accounting of certain disclosures
- Receive confidential communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

III. Our Responsibilities. New Hampshire Veterans Home is required to:

- Maintain the privacy of your health information
- Provide you with this Notice of Privacy Practices outlining our legal responsibilities and privacy practices
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests to communicate your health information by alternative means or at alternative locations

We reserve the right to change our Notice of Privacy Practices and to make the new provisions effective for all protected health information we maintain. Should our Notice of Privacy Practices change, we will notify you. The most up to date copy of this Notice of Privacy Practices will be displayed in prominent locations throughout the home.

IV. Examples of How We Will Use or Disclose Your Protected Health Information (PHI). The following are examples of the types and uses and disclosures of your PHI that we are permitted to make.

Treatment: We will use and disclose PHI to provide, coordinate, or manage your health care and any related services. For example, we may disclose PHI to your primary care physician and to other physicians who may be involved in your health care. In addition, we may disclose PHI to other health care facilities that are providing your care, such as hospitals and ambulance services, to coordinate continuing care, diagnostic testing, surgery, therapy and other services.

Payment: PHI will be used as needed to obtain payment for services that we provide to you. For example, we may disclose PHI to the Department of Veterans Affairs for benefits such as per diem payments, pharmacy and other medical benefits. We may disclose PHI to your health insurance company and its legal representatives.

Healthcare Operations: We may use or disclose your PHI as needed to support our own business activities. These activities may include quality assessment and improvement, training and supervision of staff members, or other business activities. We may share your PHI with other departments within the Home for such activities as preparing and serving of meals, housekeeping, and participation of recreational activities. For example, we may share your PHI with third party business associates that perform various services that are essential to our Home, such as Physician, Pharmacy, Dental, Rehabilitative

and Speech Services. We will limit the amount of PHI that we provide to the minimum necessary to accomplish the particular task. We will have a written contract with Business Associates that contains terms that will protect the privacy of your PHI. We will use your protected health information to provide you with appointment reminders and to discuss treatment options or other health related benefits that may be of interest to you.

V. Uses and Disclosures We May Make Unless You Object. In the following situations, we may disclose your protected health information unless you request not to:

- To notify or assist in notifying a family member or personal representative of your health status. This person will be listed in our records as your primary person to notify. If unable to contact this person, the person listed as your secondary contact may be notified in an emergency situation.
- Your name and room number will be listed on a Home directory. Your location within the home may be released to anyone that asks for you by name. Your name will also be located on a nameplate out side your door.
- Your name, location and religious preference may be shared with clergy.
- Your name, location, service information such as branch of service, war service (WWII, Korea, etc.), and service organizations (VFW, AL, etc) may be shared with members of visiting service organizations.
- Your name and birthday will be displayed on the Home's monthly birthday list.
- Your name, basic information, such as demographics may be included in our quarterly newsletter.

VI. Uses and Disclosures Not Requiring Your Authorization. The federal privacy rules provide that we may use or disclose your protected health information without your authorization in the following circumstances (in accordance with applicable state and federal law):

- As required by Law – to the extent that the use or disclosure is required by state or federal law
- Health Oversight Activities – in the context of audits, investigations, inspections and licensing activities
- Food and Drug Administration (FDA) – to report adverse events with respect to food, medications, products, and product defects
- Public Health – to public health authorities charged with preventing or controlling disease, injury, or disability.
- Relating to Decedents – regarding an individual's death, to coroners, medical examiners or funeral directors.
- Organ/Tissue Donation – if you are an organ donor, to assist in procurement, banking or transportation of donated organs or tissue
- Law Enforcement – as required by law or in response to a valid search warrant or court order
- Legal Proceedings – in response to an order of a court, subpoena, discovery request or other lawful process
- To Avert a Serious Threat to Health or Safety – to warn of a resident's violent behavior when a resident has communicated a serious threat of physical violence against a reasonably identifiable victim
- Criminal Activity – to law enforcement authorities if evidence of criminal conduct on our premises, to report suspected child abuse or neglect, or abuse of incapacitated adults, or an injury that we believe may have been a result of an illegal act
- National Security and Intelligence Activities – to authorized federal officers for national security activities

VII. Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described in this notice. You may revoke this authorization at any time in writing, except to the extent that we have already relied upon your authorization in making a disclosure.

VIII. For More Information or to Report Complaints

If you wish to exercise any of the rights outlined in this notice or if you have questions and would like additional information, you may contact our Privacy Officer at New Hampshire Veterans Home, 139 Winter St., Tilton, NH 03276 . Telephone: (603) 527-4400.

If you believe that your privacy rights have been violated, you may file a complaint with our Privacy Officer. If you are not satisfied with the Home's response, you may file a complaint with the Regional Office for Civil Rights. All complaints must be submitted in writing. You will not be retaliated against for filing a complaint. To file a complaint with the government, contact: Office for Civil Rights – Attn: Regional Manager, U.S. Department of Health and Human Services, JFK Federal Building – Room 1875, Boston, MA 02203 / (617)565-1340, (617)565-1343 (TDD)

New Hampshire Veterans Home
Consent to Treatment, Use of Health Care Information,
and Receipt of Privacy Notice

Resident: _____ MR Number: _____

_____ **(please initial) 1. Consent for Care and Treatment**

I hereby authorize New Hampshire Veterans Home, its staff, practitioners, and others involved in the provision of services on its behalf, to examine me, secure appropriate information, and perform any routine treatment that may be appropriate for my condition. I understand that the practitioner or other responsible person will explain to me any particular treatment, including both its benefits and its risks, and that I have the right to refuse any proposed treatment.

_____ **(please initial) 2. Consent to Use of Health Care Information**

I understand that New Hampshire Veterans Home will make use of my health care information for purposes of treatment and other lawful functions including securing payment and other usual health care operations. I understand that this information may be available to persons working on behalf of New Hampshire Veterans Home, who will be subject to the same duty of confidentiality as New Hampshire Veterans Home with respect to my information. I understand that if New Hampshire Veterans Homes holds certain sensitive information related to my health care such as (i)records covered by federal law governing confidentiality of alcohol or drug abuse treatment programs; (ii) records covered by state rules governing the rights of recipients of mental health services;, or (iii) records concerning my diagnosis or treatment for HIV infection, then my specific authorization will be required to disclose such information to others. However, I consent to the use of such information by New Hampshire Veterans Home for purposes of my evaluation and treatment. I understand that I may refuse to allow the sharing of some or all such information, but that refusal may result in improper diagnosis or treatment or other adverse consequences.

_____ **(please initial) 3. Acknowledgement of Receipt of Privacy Notice**

I acknowledge receipt of the Notice of Privacy Practice for Protected Health Information from New Hampshire Veterans Home. I understand this notice contains important information about how my medical information may be used and disclosed and how I can get access to this information

_____ _____
Patient or Authorized Representative Date

Relationship to resident: _____ Self _____ Guardian

_____ DPOAHC _____ Other (Please specify)_____

New Hampshire Veterans Home
Security Form

Please read this form carefully and sign as instructed with the date. Your witness does not have to be a Notary.

If you have ever been convicted of a crime (Felony or Misdemeanor) that has not been officially annulled by a Court, you **MUST** complete the following section, giving the date, location and nature of the Felony or Misdemeanor conviction. If you leave this space blank; you are certifying that you have no current record of conviction.

Please note: Conviction is not an automatic disqualification for Admissions to the NHVH. Each case is considered individually. Willful omission or misrepresentation of required information will be a basis for rejection of your application to the NHVH.

_____ _____

Witness Signature (required) Veteran's Signature or legally authorized Person (DPOAHC/Guardian)

_____

Date

New Hampshire Department of Safety

DIVISION OF STATE POLICE

Central Repository for Criminal Records

33 Hazen Drive, Concord, NH 03305

CRIMINAL RECORD RELEASE AUTHORIZATION FORM

SECTION I

PLEASE TYPE OR PRINT CLEARLY, ALL INFORMATION IN THIS SECTION **MUST BE COMPLETED**

NAME_____
LAST (MAIDEN / ALIAS) FIRST MI

ADDRESS_____
STREET CITY STATE ZIP CODE

DATE OF BIRTH_____ HAIR COLOR_____ EYE COLOR_____ SEX_____

DRIVER LICENSE NUMBER_____STATE_____

PURPOSE FOR RECORD: ☐Housing ☐Employment ☐Annulment/Expungement ☐Other _____
Specify

My below signature certifies that I am the individual listed above and that the information provided is true.

YOUR SIGNATURE:_____ DATE_____
Signed under penalty of unsworn falsification pursuant to RSA 641:3.

SECTION II

IF RECORD IS TO BE MAILED **TO YOU, OR** RECEIVED BY SOMEONE OTHER THAN YOURSELF,

ALL OF SECTION II MUST BE COMPLETED

I hereby authorize the release of my criminal record conviction(s), if any, to the following individual:

New Hampshire Veterans Home
NAME OF PERSON / FIRM TO RECEIVE RECORD

ADDRESS 139 WINTER ST. TILTON , NH 03276
STREET CITY STATE ZIP CODE

APPLICANTS SIGNATURE_____DATE_____

NOTARY'S SIGNATURE_____ DATE_____
(Affix Seal) (Comm Exp.)

_____DATE_____
Signature of person / firm to receive record